CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING PROVIDER

A participating provider is a person who has a current, signed Participation Agreement with the Department of Medical Assistance Services.

PROVIDER ENROLLMENT

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid recipients. A copy of the Participation Agreement can be found within this chapter. All providers must sign the appropriate Participation Agreement and return it to the First Health Provider Enrollment Unit; an original signature of the individual provider is required.

Upon receipt of the above information, a seven-digit Medicaid identification number is assigned to each approved provider. This number must be used on all claims and correspondence submitted to Medicaid.

This manual contains instructions for billing and specific details concerning the Medicaid Program. Providers must comply with all sections of this manual to maintain continuous participation in the Medicaid Program.

REQUESTS FOR PARTICIPATION

To become a Medicaid provider of services, the provider must request a Participation Agreement by writing, calling, or faxing their request to:

First Health
VMAP-PEU
PO Box 26803
Richmond, VA 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Licensure by the Health Regulatory Board or the Board of Opticians does not constitute automatic enrollment as a Medicaid provider.

PARTICIPATION REQUIREMENTS

All ophthalmologists, optometrists, and opticians enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider agreements. The requirements for providers in this category include:

- Any ophthalmologist, optometrist, or optician licensed to practice that profession in the Commonwealth of Virginia (or in the state in which the practice is located) may apply for participation in the Virginia Medicaid Program by signing the authorized participation agreement (DMAS-101, see "Exhibits" at the end of this chapter). The agreement must be in effect at the time services are rendered in order for them to be considered for payment. Each optometrist and each optician (optical company) will be assigned a Virginia Medicaid provider number.

- To become a Medicaid provider of services, providers must obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid recipients.

- Provision of services to Medicaid recipients must be without regard to race, color, or national origin.

- Keeping of records necessary to fully disclose the extent of services provided to individuals receiving assistance under the State Plan; provision of information to the State Agency regarding these claims as requested; and access to records and facilities by personnel of the Department of Medical Assistance Services, the Office of the Attorney General, and federal personnel.

- Acceptance of payment by Medicaid as payment in full. The provider should not attempt to collect from the recipient, or the recipient's responsible relatives(s), any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third party payer reimburses $5.00 out of an $8.00 charge and the Medicaid allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Agreement to abide by Medicaid policies and procedures.

- Allowance of freedom of choice in the selection of a provider service.

DOCUMENTATION OF RECORDS

The provider agreement requires that the records fully disclose the extent of services provided to Medicaid recipients.

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every office, clinic, or hospital visit billed to Medicaid.

TERMINATION OF PROVIDER PARTICIPATION

The participation agreement is not time-limited, and will only expire upon the lapse or loss of licensure or certification of the provider, action taken by DMAS to meet the requirements of the agreement, regulations or law, inactive participation by the provider (no billing within 36 months), or resignation by the provider. DMAS will request a copy of the renewed licensure/certification prior to its expiration.

A participating provider may terminate participation in Medicaid at any time. Thirty (30) days' written notification of voluntary termination should be made to the Director, Department of Medical Assistance Services and First Health Provider Enrollment Unit.

DMAS may terminate a provider from participation upon thirty (30) days' written notification. Such action precludes further payment by DMAS for services provided recipients subsequent to the date specified in the termination notice.

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he

or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mailing Suspension Request form and return it to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration of the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have 30 days' notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 2.2–4000 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

Repayment of Identified Overpayments

Pursuant to Section 32.l-325.l of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to of the Code of Virginia, Section 32.l-3l3.l. Repayment and interest will not apply pending appeal. Repayment schedules must ensure full repayment within l2 months unless the provider demonstrates, to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

EXHIBITS

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Commonwealth Of Virginia
Department of Medical Assistance Services
Medical Assistance Program
Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ ☐ _____ Check this box if requesting new number→ ☐

☐ If you wish to be a MEDALLION PCP, check this box. The MEDALLION provider enrollment form must be attached.

☐ If you are already a MEDALLION provider, check this box.

This is to certify:

	PAYMENT/CORRESPONDENCE ADDRESS	**PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)**
INDIVIDUAL NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider is authorized to practice under the laws of the state in which he is licensed and practicing and is not as a matter of state or federal law disqualified from participating in the Program.**
2. **Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.**
4. **The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.**
5. **Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.**
6. **The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the Program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **If qualified to be a Primary Care Provider, the applicant agrees to comply with all applicable MEDALLION state and federal laws, administrative policies and procedures of DMAS, and the requirements identified in Appendix A as from time to time amended.**
12. **This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.**

For First Health's use *only*

Director, Division of Program Operations Date

For Provider of Services:

Original Signature of Provider **Date**

Provider Specialty

_____City OR _____County of _____

Board License Number **(Area Code) Telephone Number**

IRS Identification Number (Required) **UPIN**

Medicare Carrier and Vendor Number

IRS Identification Name (Required)

mail or fax **one** completed **original** agreement to:

First Health - VMAP-Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803
1-804-270-7027

First Health Services Corporation

MAILING SUSPENSION REQUEST
SERVICE CENTER AUTHORIZATION
SIGNATURE WAIVER
PHARMACY POINT-OF-SALE

Please review and check the blocks which pertain to you:

- ☐ **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid memos, forms, or manual updates under the Medicaid provider number given below.

- ☐ **COMPUTER GENERATED CLAIMS:**
  I certify that I have authorized the following service center to submit computer-generated invoices (by modem, diskette or tape) to Virginia Medicaid:

  _____
  (Service Center Preparing Invoices)

  Service center code: _____ **Magnetic Tape RA:** YES NO (Circle One)

  Prior service center code: _____

- ☐ **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid which contain my typed, computer generated, or stamped signature.

- ☐ **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

PROVIDER NUMBER: _____ Leave blank, if number pending.

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return completed form to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803